Increasing Cultural Competency and Health Literacy

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Learning Objectives

Upon completion of this program participants will be able to:

1. Characterize the evolving cultural diversity in the United States
2. Understand how a cultural disconnect can have a negative impact on access to healthcare
3. Identify the health and healing beliefs most closely associated with traditional Hispanic, Asian, African, Middle Eastern, and European cultures, including folk illnesses, healers, and remedies.
4. Discuss proven methods for eliciting a patient's health and healing beliefs.
5. Describe effective approaches to communicating with patients who speak languages other than English, including appropriate use of interpreters.
6. Advocate changes in your practice to overcome literate and cultural difference to improve patient care.

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Definitions

- Culture: set of learned and shared beliefs and values that shape interactions and interpretation of experience; each of us can belong to many different cultures.
- Ethnicity: self-defined groups, identity that is based on religion, nationality, and cultural patterns
- Race: a social and political construct having no scientific basis

The Impact of Culture

- Health beliefs
- Life expectancy
- Disease burden
- Literacy and opportunity

Your own cultural background

- What is your cultural heritage?
- Where did your parents/grandparents/great grandparents come from?
- What were/are some foods, celebrations, rituals, clothing, etc that were meaningful to your family and symbolized your cultural background?
- How do you define health?
- How do you keep yourself healthy?
- How do you define illness? What causes illness?
- What would you define as a minor, or non-serious medical problem?
- How do you know when a given health problem does not need medical attention?
- What health problems do you self-diagnose?
- Who do you seek for help with minor health problems? Major health problems?
- Do you use over the counter medications? Which ones, and when?
- Who makes health care decisions in your family?
- What expectations are there for who is to care for an elderly relative?

US Census Data

People Quick Facts 2000	US%	CA%	SD%	LA%
White, not Hispanic/Latino	69.1	59.5	88.7	63.9
Black/African Americans	12.3	6.7	0.6	32.5
American Indian/Alaskan Native	0.9	1.0	8.3	0.6
Asian	3.6	10.9	0.6	1.2
Native Hawaiian/Pacific Islander	0.1	0.3	-	-
Hispanic/Latino	12.5	32.4	1.4	2.4

U.S. Census Bureau, State & County QuickFacts, http://quickfacts.census.gov/qfd/ accessed January 18, 2006

County Data

- Language other than English spoken at home
  - U.S. Total: 18%
  - San Francisco County, CA: 45.7%
  - Merced County, CA: 45.2%
  - Millette County, SD: 15.8%
  - St. Bernard Parish, LA: 7.3%
  - Apache County, AZ: 61.7%

U.S. Census Bureau, State & County QuickFacts, http://quickfacts.census.gov/qfd/ accessed January 18, 2006

Health Disparities

- Racial or ethnic differences in the quality of healthcare
  - Worse clinical outcomes
  - Persist after adjusting for known factors.
    - Socioeconomic factors
    - Patient preferences
    - Appropriateness of intervention
  - Examples: heart disease, cancer, pain, asthma

Health Disparities

- Breast Cancer
  - Field TS, et al, J.Natl Cancer Inst Monogr. 2005; (35):88-95
  - Maly RC, et al, Cancer. 2006, Jan 9
- Hypertension
  - Hertz RP, et al, Arch Intern Med. 2005 Oct 10; 165(18):2098-104
- Mental Health
  - Han E and Liu GG, J Ment Health Policy Econ. 2005 Sep;8(3):131-43
  - Mallinger JB, et al, Psychiatr Serv. 2006 Jan;57(1):133-6

Potential Sources of Disparities?

- Health Perception
- Treatment Preferences
- Communication
  - Verbal
  - Nonverbal
- Socioeconomic status
- Social class
- Literacy level

Literacy and Health Care

- Literacy is the strongest predictor of health care: the ratio is 4:1.
- Immigrants are in peril
- Do not fit in Western health scheme
- May delay treatment
- May misunderstand instructions
- May take medications incorrectly

Examples

- The working poor
- The Middle Eastern medical student
- The Hispanic telecommunications worker
- The hysterectomy
- Trouble with insurance
- Understanding the prescribed treatment
- 50% of medication is taken improperly

Compare and Contrast "Explanatory" models for sickness

- Origin of sickness varies greatly by culture
- Western medical model is very different from the Eastern model
- Expectations for "cure" or recovery are different
- The expectation of the time component is very different

Western Health Model

- Illness is hereditary
- Illness is environmentally caused
- Illness is caused by specific microbes or viruses
- Illness is caused by age and “wearing out”
- Illness should be short-term

Native American Model

- Illness is caused by lack of harmony with the environment and others
- Illness may be caused by improper behavior
- Illness may come on slowly

African American Model

- Illness may be caused by bad habits
- Illness may be God's punishment
- Illness may be caused by a spell
- OR may believe in Western model

Chinese/Asian (Eastern) Model

- Many ethnic variations are possible
- Imbalance between *Yin* and *Yang*
- Lack of/interruption of *chi*
- Above noted balance is quite complex
- Immediate cure may not be expected

Hispanic Model

- Many variations are possible
- Predestination, God's will, punishment
- Imbalance of hot and cold (the shower)
- Shock, *susto, mal de ojo*
- Curse

Middle Eastern Model

- Imbalance
- Going against one's humoral/natural temperament
- Bad luck
- Deprivation

Associated Health and Healing Beliefs

- For the provider:
- Be non-judgmental
- Facial judgment will stop any exchange or dialogue
- Seek to understand and preserve as many customs and beliefs as possible
- Encourage spiritual connections

Western (European) Model

- See a doctor and get a prescription
- Consider vitamins or self-medicate
- Find the right “cure”
- Rest, relaxation may help

Native American Model

- Self-care and self-healing, holistic treatment
- Seek harmony with nature, others
- Prayer, fasts, herbs, sweat lodge
- May consider Western medicine if severe
- Often delay seeking Western treatment

African American Model

- May have complete buy-in of Western model
- May seek spiritual counsel, faith healing
- May seek removal of a “spell”
- May attempt to improve health practices

Asian Model

- Will seek to restore balance and increase in *chi*
- May feel/derive more comfort from herbal treatments
- May seek Western medicine for acute/severe illness
- Southeastern cultures may seek relief from “spells” and may seek traditional healers

Hispanic (generalizations)

- May use Western model
- May conceal use of traditional medicine or *curandero/a*
- May assume sick role; feel very stressed
- May seek spiritual help
- Example of the sore heel
- Often trust in close friends, godparents (*comadre)*

Middle Eastern

- Avoid hot/cold
- Seek to restore balance
- Often has respect for traditional cures and advice
- May combine models

Communicating with Non-English Speakers

- Using Interpreters
  - Talk directly to the patient
  - Keep sentences brief and clear
  - “Language Line”
- Learn a few phrases in common languages
- Written materials in native language
- Be aware of and enlist culturally-based resources.

Determining the client/patient's health and healing beliefs

- Determine country of origin and language ability
- Determine length of time in U.S. and acculturation
- Determine visual ability/reading
- Availability of resources?
- Determine food preferences

Kleinman's questions

- What do you call the problem?
- What do you think has caused the problem?
- Why do you think it started when it did?
- What do you think the sickness does? How does it work?
- How severe is the sickness? Will it have a short or long course?
- What kind of treatment do you think the patient should receive? What are the most important results you hope she receives from this treatment?
- What are the chief problems the sickness has caused?
- What do you fear most about the sickness?

Kleinman, A, Eisenberg, L, Good, B, (1978). Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med. 88(2), 251-8

Changing Your Practice

- Models of acceptance
- The business perspective
- It is the law

Models of Acceptance

- Bennett Model
  - Denial
  - Defense
  - Minimization
  - Acceptance
  - Adaptation
  - Integration
- Cross Model
  - Destructiveness
  - Incapacity
  - Blindness
  - Pre-contemplation
  - Basic competence
  - Advanced competence

National Standards for Culturally & Linguistically Appropriate Services in Health Care (CLAS)

- Culturally competent care
  - Care that is compatible with cultural health beliefs, practices, preferred language
  - Diverse staff and leadership
  - Education and training in CLAS

CLAS Standards, continued

- Language Access Services
  - Offer and provide language assistance services at no cost, in a timely manner
  - Verbal and written notice of right to receive language assistance services
  - Family and friends should not be used except when requested by the patient
  - Materials and signs in languages commonly encountered

CLAS: Language Access Services

- *Based on Title VI of the Civil Rights Act of 1964 with respect to services for limited English Proficiency (LEP) individuals*
- Std 4: Offer and provide language assistance services at no cost and in a timely manner
- Std 5: Both verbal and written notice of their right to receive language assistance services

CLAS: Language Access Services

- Std 6: Family and friends should not be used to provide interpretation services except when requested by the patient
- Std 7: Easily available materials and signage in languages commonly encountered or represented in the service area

CLAS, continued

- Organizational supports for cultural competence
  - Strategic plans
  - Self-assessments
  - Data collection
  - Community profile
  - Partner with community
  - Conflict resolution
  - Public information

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Diabetes

By
Ann Marie Brooks MSN, BC-ADM
with Utah Diabetes Control Program

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توسط : أن مِری بروکس

By: Ann Marie Brooks
MSN, BC-ADM

با همکاری سازمان کنترل مرض قند یوتا

Diabetes, Farsi Version, in cooperation with Utah Diabetes Control Program.

Bệnh Tiểu Đường

Diabetes – Vietnamese Version
By
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By
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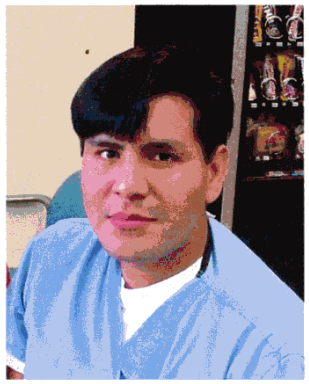
Elizabeth Cho, MSN

April 2003



La Diabetes

Por Ann Marie Brooks, MSN
con
Leyla Chorro y Galo W. Cruces

July 2002

APhA Annual Meeting & Exposition 2006
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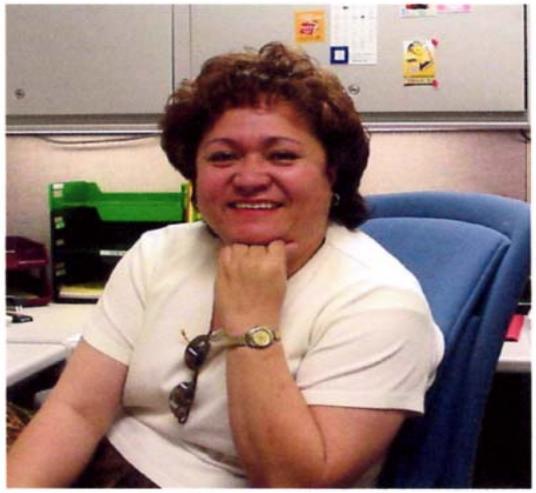
ДИАБЕТ

Анна Мари Брукс

Программа по контролю за диабетом в штате Юта

Russian Version: Basic Diabetes Education

O le Ma'i O le Suka



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Ann Marie Brooks, MSN, CDE

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Diabetes

Napisala: Ann Marie Brooks MSN CDE

Dali ideje i preveli: Dubra Šašivarević RN

novembar 2002

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Mahaki Ko e Suka´

Fai´e
Ann Marie Brooks, MSN, CDE
&
Kulaea Taulanga, RN

السُكرّي

مؤلفة: آن مري بروكس
مع برنامج يوتا للتحكم في مرض السكري

Basic Diabetes Education, Arabic Version
By Ann Marie Brooks, MSN, with Utah Diabetes Control Program.
2005

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- www.health.utah.gov/diabetes